

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)

01/07/2010

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 01/07/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee arthroscopy with meniscectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas State Licensed MD Board Certified Orthopaedic Surgeon

REVIEW OUTCOME Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment 12/22/2009
2. Notice of assignment to URA 12/22/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 12/22/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 12/21/2009
6. HDI letter 12/17/2009, 11/23/2009
7. Letter from MD 12/03/2009, pt face sheet, medical note 11/12/2009, interpretation 11/12/2009, radiology report 11/03/2009 & 10/27/2009
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This patient sustained injury to the knee on xx/xx/xx. The treating physician assessed this patient on November 12, 2009. That is, the patient was seen 16 days following the injury. There is no indication in the initial evaluation that the patient had any specific treatment. Specifically, there is no indication that he had activity modification, physical therapy, or rest. Based on MRI scanning, it was recommended that he undergo surgery.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Based on the Official Disability Guidelines, the previous adverse determination is upheld. Using the Official Disability Guidelines, there needs to be documentation of non-operative treatment. The records reviewed do not support the medical necessity of this request.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)